Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

Respondent Name
BROWNSVILLE ISD

Carrier's Austin Representative Box
Box Number 29

MFDR Tracking Number
M4-14-1155-01

MFDR Date Received
DECEMBER 23, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary submitted by Mary Watkins/Ombudsman Supervisor: "[Injured Worker] submitted a request for reimbursement to Leticia Galaviz, Adjuster. His request was denied by Ms. Galaviz for the reason that the office visits were not under workers' compensation. However, [injured worker's] case was denied by the Carrier in its entirety (see attached letter from Tristar). Subsequently, [injured worker] sought dispute resolution and the Hearing Officer determined that [injured worker] sustained a compensable injury on October 3, 2012 and disability as a result of the compensable injury… [Injured worker] had not other alternative but to seek medical treatment with Dr. Factoriza because the Carrier denied his claim. Therefore, [injured worker] respectfully requests to be reimbursed the amount of $240.00."

Amount in Dispute: $240.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier wills stand on the denial of the request for reimbursement made the basis of this medical fee dispute. The treatment for which reimbursement has been requested was not treatment for the compensable injury nor was it by or at the direction of the treating doctor."

Response Submitted by: Pappas & Suchma, PC, PO Box 66655, Austin, TX 78766

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 31, 2012 through November 26, 2012	Office Visits and Physical Therapy	$240.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.270 sets out the procedures for injured workers' out of pocket expenses for the compensable injury.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
    - The insurance carrier did not submit EOBs to the injured worker. The insurance carriers TPA, Tristar,

elected to send a letter to the injured worker, stating in part, “Unfortunately, this will not be able to be honored as you were not seen for these services under worker’s compensation.”

Issues

1. Did the requestor pay out of pocket for medical expenses incurred for the compensable injury?
2. Was the request for medical fee dispute resolution timely filed?
3. Is the requestor entitled to reimbursement?

Findings

1. According to the Decision and Order of the Hearing Officer, a benefit review conference was held on April 29, 2013 to mediate resolution of the disputed issues; however, the parties were unable to reach an agreement. A contested case hearing was held on June 25, 2013 to decide the following disputed issues: 1. Did the Claimant sustain a compensable injury on October 3, 2012 and 2. Did the claimant have disability resulting from the claimed injury, from October 5, 2012 through November 17, 2012?

   Review of the Decision and Order from the contested case hearing, dated July 5, 2013, the Hearing Office determined that the claimant sustained a compensable injury on October 3,2012 and the claimant also sustained disability as a result of the compensable injury beginning on October 5, 2012 and continuing through November 17, 2012. As a result of the contested case hearing the carrier was order to pay benefits in accordance with this decision. The carrier appealed the decision of the Hearing Officer; however, after review by the Appeals Panel it was determined that the Hearing Officer’s Decision and Order became final on September 23, 2013.

2. Per 28 Texas Administrative Code §133.307(c)(1)(B) A request may be filed later than one year after the date(s) of service if: (i) a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability.

   The Division received the request for medical fee dispute resolution on December 23, 2013; the Appeals Panel reviewed and deemed the Hearing Officers Decision and Order became final on September 23, 2013.

   The request for medical fee dispute resolution was received by the Division on December 23, 2013. Sixty days from September 23, 2013 is November 21, 2013. Therefore, this dispute was not filed timely and cannot be reviewed by Medical Fee Dispute Resolution.

3. Review of the submitted documentation finds that because the dispute was not filed within 60 days after the final decision the Division cannot review the disputed services.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 28, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.